MISSING P. 20-37
WHITE PAPER OUTLINING CENTER OF EXCELLENCE, DECEMBER 2003

A Behavioral Health Education and Research System for Nebraska

Nebraska Department of Health and Human Services

Division of Behavioral Health Services

Nebraska Behavioral Health Reform

Academic Support Work Group

Principal Writer: Susan Boust, M.D..

January 2005

NEBRASKA HEALTH AND HUMAN SERVICES SYSTEM

DEPARTMENT OF SERVICES • DEPARTMENT OF REGULATION AND LICENSURE • DEPARTMENT OF FINANCE AND SUPPORT

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Introduction

Nebraska is reforming the state behavioral health system, moving from institutional care to community care and increasing the recovery focus of services. These reform efforts are consistent with the national vision outlined by the President's New Freedom Commission final report, Achieving the Promise, Transforming Mental Health Care in America, (Hogan 2003) (Iglehart 2004), which recognized the importance of having health care providers rely on up-to-date knowledge in the delivery of services.

This need has been recognized by LB 1083, which reformed the mental health system, by state and regional leadership, by the Nebraska Academic Support Work Group, and by the Rural Health Advisory Committee. Any reform of behavioral health education in the state should be compatible with the national efforts to change behavioral health care. The President's Executive Order of April, 2002, establishing the New Freedom Commission, set forth the following principles:

1. Focus on the desired outcomes of mental health care, which are to attain each individual's maximum level of employment, self-care, interpersonal relationships, and community participation.
2. Focus on community-level models of care that efficiently coordinate the multiple health and human service providers and public and private payers involved in mental health treatment and delivery of services.
3. Focus on those policies that maximize the utility of existing resources by increasing cost effectiveness and reducing unnecessary and burdensome regulatory barriers.
4. Consider how mental health research findings can be used most effectively to influence the delivery of services.
5. Follow the principles of Federalism, and ensure that its recommendations promote innovation, flexibility, and accountability at all levels of government and respect the constitutional role of States.

Many components of the system of care will impact the success of this reform. One element of the system that is fundamental to the success of the reform is the development of a workforce that delivers the most efficient and effective services, and works with consumers to work for themselves and each other to develop the competencies that teach and promote self-directed recovery and getting a life.

It is essential that Nebraska have a well-organized behavioral health education and research system to develop the state-wide workforce necessary to support behavioral

health reform. As stated in the President's New Freedom Commission Report overview to Goal 5, "Excellent Mental Health Care is Delivered and Research is Accelerated":

> In a transformed mental health system, consistent use of evidence-based, state-of-the art medications and psychotherapies will be standard practice throughout the mental health system. Science will inform the provision of services, and the experience of service providers will guide future research. Every time any American - whether a child or an adult, a member of a majority or a minority, from an urban or rural area - comes into contact with the mental health system, he or she will receive excellent care that is consistent with our scientific understanding of what works. That care will be delivered according to the consumer's individualized plan.

Just as there is a crisis in the behavioral health service system, there is an identified crisis in the education system that produces behavioral health professionals (Hoge 2002). The education system lags behind in translating current research into training and thus into service delivery. In addition, consumers, now active in policy discussions and direct care, have been neglected in the training and education process. The Annapolis Coalition on the Behavioral Health Workforce http://www.annapoliscoalition.org/, a national coalition of American College of Mental Health Administration (ACMHA) and the Academic Behavioral Health Consortium (ABHC), addresses this in the Policy to Service report (Daniels 2005):

> A clear crisis exists in the current behavioral health workforce. The Quality Chasm report has identified this as a central factor in the process of systems reform. The President's Commission also champions the improvement and expansion of the workforce and their ability to provide evidence based care. Together, these reports suggest that there is a serious problem in the development and deployment of the professional workforce. While behavioral health care has changed dramatically over the past fifteen years, the educational systems that prepare the workforce have failed to keep pace. In addition, while the voice of the behavioral health consumer has grown in policy discussion, and their role has also proliferated in direct care, their participation in the training and education process has been limited at best. Payment and training incentives have lagged behind this expanding role.
> http://www.acmha.org/publications/From_Policy_To_Service.pdf

The Nebraska behavioral health reform would be enhanced by the development of a behavioral health education system that would increase the availability of behavior health providers to all areas of the state, assure that local service providers have knowledge and expertise in the best behavioral health practices, and ensure that the consumer's perspective be a component of education for providers.

This need has been recognized in the reform legislation, and has been addressed by Governor Mike Johanns and Senator Jim Jensen's request to the two academic health centers in the state for an outline of how the academic health centers could support system reform. A white paper outlining a Center of Excellence in Behavioral Health Care was presented to the Senator and Governor in December, 2003. [See Appendix A]

In order for system reform in behavioral healthcare to succeed, there will need to be significant changes in the behavioral health workforce, and the education and research activities that support them. Behavioral health providers will be needed in all areas of the state to provide treatment and rehabilitation services in a continuum of care ranging from

emergency services to long term care, rehabilitation and supports. Educational activities must support the extension of services to underserved geographic areas as well as the development of emerging consumer organized and operated services. The behavioral health reform legislation has charged each of the six Regions of the state with the responsibility to identify local behavioral health needs and develop a plan to meet those needs. These service plans do not address the need to train people to deliver care. Development of a behavioral health workforce requires a statewide plan to coordinate academic and education efforts across the state.

Coordinated research activities are another essential element of the behavioral health system that must be addressed. The 1990's were identified as the "Decade of the Brain" and tremendous new knowledge of brain function has been developed in the past 15 years. Translation of this knowledge into the daily practice of practitioners is so slow that it has been estimated to take 17 years to translate known science into clinical practice (Balas 2001) (Committee on Rapid Advance Demonstration Projects 2002). In its landmark monograph, Crossing the Quality Chasm: A New Health System for the 21st Century (Committee on Quality of Health Care in America 2001), the Institute of Medicine identified significant issues that impact the quality of care and that requires clinical care to be based on the best available scientific knowledge. In 2001, the ACMHA developed a companion to the Quality Chasm that focuses on the behavioral health system (Daniels 2005). The Institute of Medicine is continuing to develop quality materials focused on the behavioral health system, and a new Institute of Medicine monograph titled "Crossing the Quality Chasm - Adaptation to Mental Health and Addictive Disorders is under development. http://www.iom.edu/project.asp?id=19405

The importance of research to the national scene is indicated by the extensive funding for research in both business and government. Faculty members in academic institutions recognize that participation in research keeps them connected with the most up to date information about illness and treatment. At the local level, research activities, and academics in general, are at risk to be viewed as "ivory tower", with little to contribute to the immediate needs of the system. Appropriate research will enhance the system by decreasing the time it takes to translate science into services and by assisting payers, providers and consumers to identify the most beneficial treatments. (Ganju 2003)

Although this paper has its focus the Behavioral Health Education and Research System, it is necessary to address the interdependence between education, research and services. Behavioral health education and research activities are dependent on the service system for training opportunities and research material, and conversely, the service system cannot deliver quality services without well-trained and educated professionals. Research cannot occur without participants. Likewise, research is most meaningful when it addresses questions that have arisen in service delivery. Of particular interest is education and research that will meet the training needs for professionals throughout the state who provide care for persons with serious and persistent mental illness and co-occurring substance abuse problems that require a team of people to meet their needs. The move from institutional care to community care is especially relevant to people who have formerly received services from the Regional Centers. These people's needs are

usefully categorized under the rubric of individuals diagnosed with *serious mental illness* (SMI). In order to optimally enhance mental health reform in Nebraska, a behavioral health education center will need to address those aspects of education, training, practice and policy most pertinent to the lives of people diagnosed with SMI.

There is a concern that education and research activities will decrease the dollars available for services. There are limited dollars in the state for behavioral health activities, and the commitment has been made by the legislature that no service dollars will be used to fund the education and research effort. Likewise, the legislature has recognized the essential nature of academic support to the success of the reform effort, and the legislation requires the promotion of research and education to improve quality of services and the recruitment and retention of behavioral health professions.

Nebraska's Current Behavioral Health Education and Research System

There are numerous academic institutions in Nebraska that provide education and training for behavioral health professionals. These education programs are housed within universities and colleges across the state and are driven largely by accreditation requirements for each profession, faculty interest and expertise, student enrollment, and the availability of practicum location.

At present, behavioral health education delivery is fragmented and occurs in silos:

- Departments within academic institutions across the state recruit and train professionals such as psychiatrists, psychologists, social workers, nurses, and other professionals who work in behavioral health care
- Physician and psychology intern locations are influenced by funding available for graduate student salaries and benefits
- The State and Regions fund various workshops
- Education of substance abuse providers occurs in separate workshops and seminars
- Service provider organizations offer in-service education
- Professional societies provide various workshops
- The concept of consumers as providers is not well known in Nebraska, however peer specialists have been employed in clubhouses for six years and are required members of ACT teams.

Behavioral health education and training also occurs outside academic institutions with workshops funded by the state, regions, professional societies, drug companies, and in-service education in various provider organizations. This type of education and training is particularly important for the behavioral health system for several reasons:

- Non-professional providers, who get most of their training outside academic institutions, are important in the delivery of care (e.g., rehab workers, peer providers)
- Service delivery for persons with the most severe illness requires a team of people, and current academic training does not teach teamwork

- Continuing education improves the translation of research into service delivery
- Service delivery needs identified by the state and region can be addressed in workshops
- Cross training of professionals can be addressed (e.g., primary care doctors delivering behavioral health services, LADC/ LMHP cross training, etc.)
- Regulations may influence much of this training (LADC, continuing education requirements)

There is currently no system of behavioral health education that crosses professions and coordinates education efforts between academic institutions and community trainings. Also, there is clear evidence that the continuing education of professionals fails to translate new research findings into practice (Hoge; Tondora, and Stuart 2003;Huey 2002;Corrigan and Boyle 2003;Ganju 2003).

Education System

Practicing professionals recognize the need to collaborate with each other across disciplines in order to work as a team; however, the initial education of professionals is monolithic. What the professional gains as extensive expertise in their individual field frequently comes at the expense of learning teamwork and recovery and rehabilitation oriented skills.

The Medical College of Georgia has entered into a partnership with the Georgia Department of Human Resources that includes developing curricula for medical students and psychiatry and psychology residents that expand the recovery emphasis. A peer support specialist has been hired to work in the Department of Psychiatry and Human Behavior. www.mcg.edu/news/2005NewsRel/MHInitiative.html

Persons with serious behavioral health problems may experience long-term disability, persisting symptoms, or a relapsing course of illness, and treatment for these serious problems requires the professional to collaborate with many other providers (Kopelowicz and Liberman 1995;Hogan 2003). By the same token, it is possible for such individuals to lead self-directed and independent lives. Taking an example from general medicine, the role of the physician in the emergency room, when confronted by a patient who appears to be suffering from an acute heart attack, is very different than the role and communication skills necessary when the acute crisis is over and the focus is on regaining function and making life style changes in the rehabilitation phase of treatment. Likewise, persons with serious behavioral health problems benefit from various teams of providers and various treatment and rehabilitation techniques depending on the phase of active illness that is the current focus of treatment. (Lenroot; Bustillo; Lauriello, and Keith 2003)

The current education system does not foster interdisciplinary education in the way that practice must be accomplished. Training is driven by accreditation requirements, board

examinations, and state licensing requirements. Well established professions like medicine and nursing are slow to change. Other behavioral health professions such as alcohol and drug counselors may be better able to adjust curricula to the changing treatment requirements, however they lack a nationally recognized comprehensive curriculum and coordinated faculty. There have been efforts to train and certify peer specialists and rehabilitation workers, however these disciplines do not have nationally established training and accreditation requirements, increasing their flexibility in education but making it harder for their expertise to be recognized by licensed professionals. (Harwood; Kowalski, and Ameen 2004;Liberman and Kopelowicz 2002;Solomon and Draine 1994)

Although increased interdisciplinary education is an identified need in the educational system, it is not easy to bring about. Students expect their academic institution to prepare them for the rigors of professional practice and to cover the core educational requirements necessary in order to pass their board examinations. Also, accredited academic institutions must have an infrastructure adequate to support the education of professionals. While this infrastructure has benefits, it decreases flexibility and the ability to collaborate across departments, institutions and professions.

Research System

Mental health care is complex, expensive and important and deserves the research that is an essential component of a well-functioning system of care. There are numerous examples of academic/ service system partnerships that focus on behavioral health system research. The Agency for Healthcare Research and Quality (AHRQ) http://www.ahcpr.gov/ recognizes that research is only a beginning and not an end in itself. Connection with research can ensure that providers use best practices to deliver high-quality health care and to work with their patients as partners. Research evidence can also help patients to become better informed partners in their own care. Finally, research can help policymakers at the state and regional levels understand what they can do to improve the quality of health care for their constituents and ensuring that they have the latest information to help them make the best use of limited resources.

In Nebraska, State and Regional officials responsible for the behavioral health service system lack the resources to design and carry out the research that should guide the policy and treatment decisions. By partnering with academic institutions, which have research as a priority, these research needs can be addressed. (Bevilacqua; Morris, and Pumariega 1996) Linking research, policy making and treatment have the additional benefit of allowing researches and policy makers to learn from the insights of consumers of services and direct care staff about what they see that has worked (Blumenthal 2005). Consumers will also be direct participants, active in the planning, design, item development, survey administration, analysis and dissemination (Campbell and Schraiber 1989).

Assessment of need (GAPS)

The Annapolis Coalition has identified four paradoxes that characterize the education of providers in mental health and addiction services:
http://www.annapoliscoalition.org/about.php

- Graduate programs have not kept pace with the dramatic changes wrought by managed care and subsequent health care reforms, leaving students unprepared for contemporary practice environments.
- Continuing education models persist in using passive, didactic models of instruction that have been proven ineffective in controlled research.
- Non-degreed and bachelor-degreed direct care providers, who may have the most contact with consumers, receive very little training.
- Consumers and families, who play an enormous care giving role, typically receive no educational support.

These paradoxes must be addressed by Nebraska's behavioral health reform efforts.

Numerous efforts have been outlined to address the behavioral health education needs in Nebraska. Starting with the Center of Excellence white paper, and continuing through meetings at the state and local level focused on research and education, various proposals for a statewide education program have been outlined. This planning identifies the need for clinicians of all disciplines involved in providing behavioral health services including specialists in mental health and substance abuse to peer and primary care providers, and the need to train providers who will work in all areas of the state. One area that requires greater recognition and substantial development is the meaningful and significant inclusion of consumers, in processes such as these and including the recognition and provision of necessary supports that will enable consumers truly to participate in this processes. Involvement should be supported in ways that promote dignity, respect, acceptance, integration, and choice. Support should include whatever financial, education, or social assistance required. (NASMHPD, 1989)

The current fragmented training effort fails to encourage interdisciplinary teamwork among providers, target the highest needs in training, move training to more rural areas, obtain appropriate input from the network of agencies that will employ the trainees, and obtain sufficient grant funds. In addition, the lived experience of consumers being employed as trainers and informing professionals about training needs and similar participatory activities is not utilized in current training efforts. In terms of current training curricula, it would be important to include recovery concepts such as self-determination, empowering relationships, meaningful roles in society and eliminating stigma-discrimination and prejudice- throughout the various levels of professional and provider training.

In summary, the current education and research system in Nebraska is lacking the following:

- Training for professionals in teamwork and collaborative care

- Matching the local need for professionals with the education efforts in institutions
- Retaining trained providers in the state
- Recruiting high school and college students into behavioral health care professions
- Recruiting persons with psychiatric diagnoses into behavioral health care professions
- Support for rehabilitation workers and peer providers
- Academic support for rural rotations
- Support to keep providers updated on new treatments and best practices
- Developing research infrastructure
- Research to answer the questions important to the state and to consumers in order to inform the state about services, supports, evaluations and suggested changes.

Proposal

A Nebraska Behavioral Health Education System, composed of a Behavioral Health Education and Research Center, and six Behavioral Health Education Sites across the state addresses the needs.

Behavioral Health Education Center

A Behavioral Health Education Center would coordinate education across academic institutions and professions, support training for substance abuse, rehabilitation and peer providers, support clinical training in all areas of the state, and enhance research that improves the system of care.

The Center would have academic leadership with an Executive Committee, including representation from each participating academic institution, and would include consumers of services in sufficient numbers to make an impact and representation from the state. Faculty from UNO, UNK, UNL, Creighton, and UNMC and the consumers must work together to develop interdisciplinary education for trainees in undergraduate through post-graduate practitioners. Each of the higher education institutions and the consumer members on the coordinating committee will be allotted a budget from the state to allow faculty participation in the Behavioral Health Education Center in order to:

- develop the necessary collaborations with individuals and institutions across the state who would be providing clinical training and supervision
- modify curriculum to allow for external rotation sites
- provide supervision for local clinical training
- train students

As the center obtains further grant money, participation would be open to other academic campuses within the state. The Center would provide coordination and support for behavioral health sites throughout the state.

This faculty must also:

- collaborate with local providers and consumer and family communities to provide clinical supervision
- develop a continuing education curriculum which disseminates best practices throughout the state
- partner with consumers of services in curriculum development, education delivery, and the development of peer providers roles

The education to support behavioral health reform should include:

- education and re-training to support the paradigm shift to self-directed recovery, peer supports, community services, and independent community living.
- knowledge of and use of current best practices
- an effort to recruit and retain providers, including consumers, in all areas of the state
- expertise in the use of technology, including tele-health, to support education and outreach services
- research that supports the needs of the state that are relevant to consumers and involve consumers beyond the role of subject
- multidisciplinary training across professions and academic institutions, that reflects the teamwork needed in service provision

In order for the clinical training to occur in an interdisciplinary manner, the education center must be co-located with comprehensive services. The service location must be designed to support and facilitate education. This co-location has the advantage of directly connecting service to education, facilitating tele-health and outreach of services to other areas of the state functioning as a clearing house for education and training efforts across the state, facilitating financial support from grants, and providing an infrastructure to organize statewide behavioral health education and research. Faculty members from UNO, UNK, UNL, Creighton University, and UNMC would provide multidisciplinary supervision and teaching on-site and facilitate clinical supervision to trainees in all areas of the state. Educational facilities should include an auditorium, conference rooms, observation rooms for clinical training, a behavioral health library, offices for faculty and trainees, and tele-health and distance learning equipment and support staff. However, the primary educational facility shall be the community. The budget for this statewide education effort must be considered separately from the budget for services.

Behavioral Health Education Sites

Every area in the state needs well trained providers of behavioral health care. Sites in all areas of state would be provided their own budget and support from Area Health

Education Centers (AHEC). These plans for behavioral health education sites follow the successful Rural Health Education Network [Appendix B] model already available in Nebraska. Each training site would have local control of the professions that are the focus of training as well as recruitment and retention and would be expected to work with the Behavioral Health Regions and their Advisory Committees. A local coordinator would identify and recruit preceptors and assist with the arrangements for housing, meals, transportation and other services to facilitate student participation in rural rotations from the academic center partners. Plans include development of two rural sites each year during a three year period for a total of six sites throughout the state being operational at the end of three years. Tentative sites include Scottsbluff, North Platte, Grand Island, Norfolk, Lincoln, and Omaha.

Research

Research is an essential component of Nebraska's academic departments, and academic research activities can be developed which can:

- improve the system of care in Nebraska via services evaluation and outcomes research
- train, develop and involve consumers in services evaluation and outcomes research and all aspects of service planning and delivery
- teach clinicians "best practices" for high-quality and cost-effective care
- leverage federal, private and foundation sources for enhanced funding
- involve Nebraskans in leading edge research that translates advances in neuroscience, telemedicine and service optimization into genuine patient recovery
- collaborate with the private sector to study workplace behavioral health issues, reasonable accommodations and intervention strategies

Academic support for system and outcome research should focus on the questions of most interest to the state:

What services work best?
What is the most efficient and effective delivery of service for each problem?
Are our educational efforts being translated into improved service delivery?

Also, on the part of recipients of services, is the research relevant, asking such questions as "what could have prevented people from being committed". Also, "what effect does involuntary treatment have on the use of voluntary services?" (Campbell and Schraiber 1989)

The Center will focus initial research activities on the special issues of highest interest to the state, such as epidemiology issues pertaining to people in Nebraska who have been diagnosed with severe and persistent mental illness, and new treatment evaluation and the identified manifestation and application for the paradigm shift to person-centered hope-oriented lives in the community. Examples of research activities that could eventually lie within the Center's scope include:

- Epidemiology (incidence and distribution of mental illness of various types and severity)
- Outcomes research (effectiveness of treatments and services approaches)
- Cost-effectiveness research (analysis of the costs compared to the benefits of treatments and other services)
- Public safety data
- Risk assessment and management research (analysis of the impact of clinical practice and related activities on public safety)
- New treatment development (developing and testing new treatments)
- Translational research (applying basic science to clinical problems)
- Workforce research (Tracking behavioral health professionals across disciplines in order to analyze demographic and workforce trends)
- Dissemination and implementation research

Later studies will focus on best practices and evidence-based practice to improve the quality of care available in local communities. State funded outcome-research activities will be developed in collaboration with HHSS behavioral health leadership. State funded personnel will provide the infrastructure to develop the research component.

With some state support, Nebraska can develop a multi-institutional, inter-disciplinary academic group oriented towards developing a comprehensive, statewide research infrastructure for policy-relevant mental health services research. (Hoge 2002) This group can continue the work of the Academic Support Workgroup by developing best practice guidelines and Tele-Health Network, providing infrastructure support for grant applications, and assisting the state and regions in developing the data to answer their most pressing policy questions.

Conclusion

Nebraska is beginning the behavioral health transformation process that will make it possible to meet the goals outlined in the President's New Freedom Commission report:

1. Americans Understand that Mental Health is Essential to Overall Health
2. Mental Health Care is Consumer and Family Driven
3. Disparities in Mental Health Services are Eliminated
4. Early Mental Health Screening, Assessment, and Referral to Services are Common Practice
5. Excellent Mental Health Care is Delivered and Research is Accelerated (that is where the "scientific is in "Understanding the Goal' section that comes after it.
6. Technology is used to access mental health care and information.

In order to meet these goals it is necessary to move from a separated and fragmented system of behavioral health education and service to one in which service, education, research, and consumer participation will become fully integrated and thus benefit from the particular perspective that each entity has as its focus.

At present, those involved in service delivery must meet the ever present and pressing need for providing care. Educators are concerned with preparing students to join the behavioral health workforce in a variety of careers and providing continuing education for those who are already part of the workforce. Researchers, lacking support to direct their efforts to the state's most pressing issues, focus on areas where grant support is more readily available. And the unique and personal experience of consumers is only beginning to be heard, acknowledged, and valued by the other behavior health entities.

Although the work of each discipline is equally important and dependent on the others, The Nebraska Behavioral Health Education Center and Sites will remove the barriers that exist between disciplines and provide collaborative bridges among service providers, educators, researchers and consumers so that the New Freedom Commission statement, "...excellent care that is consistent with our scientific understanding of what works" will be a reality in Nebraska. In addition, the Center and Sites will provide new avenues for dealing with the educational and service barriers that exist because of the distance between urban and rural populations, among diverse populations, and between providers and consumers of services. Finally, those individuals in state government who are charged with policy making and funding decisions will have support for the state's academic institutions in their effort to transform the behavioral health system.

Therefore, it is strongly recommended that the state develop a separately funded Nebraska Behavioral Health Education and Research System to meet the workforce and research needs of the state. This initial investment will improve behavioral health care in the state and assist in the development of external grant funding to support behavioral health education and research.

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Nebraska Behavioral Health Reform Project
Academic Support Work Group Participants 2004 -5

Debra Anderson, PhD
Assistant Professor
School of Social Work
University of Nebraska-Omaha
Omaha NE

Cecilia R. Barron, Ph.D., RN
Coordinator, Advanced Practice Psychiatric Nursing
University of Nebraska Medical Center
Nebraska Medical Center
Omaha, NE

Susan Boust, M.D.
Associate Professor
Division Director Public and Community Psychiatry
University of Nebraska Medical Center
Omaha NE

Robert Bowman, M.D.
Associate Professor
Department of Preventive and Societal Medicine
University of Nebraska Medical Center\
Omaha NE

Robert Bussard MPA,
Program Specialist,
Division of Behavioral Health Services
Nebraska Department of Health and Human Services,
Lincoln NE

Mark P. Christiansen, MS, MPAS, PA-C
Assistant Professor and Clinical Coordinator
Physician Assistant Program
University of Nebraska Medical Center
Omaha NE

Steve Curtiss, Director
Nebraska Department of Health and Human Services Finance and Support
Lincoln NE

Joe Evans, Ph.D.,
Chief of the Pediatric Psychology Department
Munroe-Meyer Institute
University of Nebraska Medical Center
Omaha NE

J. Rock Johnson, J.D.
Advocate
NE Legislative Behavioral Health Oversight Commission
Lincoln NE

Roxanna Jokela, MHA
Director - Rural Health Education Network
Deputy Director - Nebraska AHEC Program Office
University of Nebraska Medical Center
Omaha, NE

Christopher J. Kratochvil, M.D.
Associate Professor
Department of Psychiatry
University of Nebraska Medical Center
Omaha NE

Keith Mueller, Ph.D.
Director, Nebraska Center for Rural Health Research
University of Nebraska Medical Center
Omaha NE

Jodi Polaha, Ph.D
Assistant Professor of Pediatrics
Department of Psychology
University of Nebraska Medical Center
Omaha NE

Richard Raymond, M.D.
Chief Medical Officer
Nebraska Department of Health and Human Services
Lincoln NE

William Roccaforte, MD
Residency Program Director
Nebraska Psychiatry Training Program
Creighton University
Omaha NE

Blaine Shaffer, MD
Chief Clinical Officer
Division of Behavioral Health Services
Nebraska Department of Health and Human Services
Lincoln NE
Professor & Vice Chair
Department of Psychiatry
University of Nebraska Medical Center
Omaha NE

Michael Shambaugh-Miller, Ph.D.
Assistant Professor
Medical Geographer
Health Services Research and Rural Health Policy Section
Department of Preventive and Societal Medicine
University of Nebraska Medical Center
Omaha NE

Craig W. Smith, PhD,
Associate Professor
Marriage and Family Therapy Program,
University of Nebraska-Lincoln,
Lincoln NE

Dennis Snook, MPA
Program Specialist/State Methadone Authority
Division of Behavioral Health Services
Nebraska Department of Health and Human Services
Lincoln NE

Will Spaulding, Ph.D.
Professor Department of Psychology
University of Nebraska – Lincoln
Lincoln NE

Kate Speck, Ph. D.
Assistant Professor
Doane College
Director Nebraska Addictions Technology Training Center
Lincoln NE

Thomas Svolos, MD
Vice-Chairman, and Assistant Professor
Crieghton University Medical Center
Department of Psychiatry
Omaha NE

Dan Wilson, M.D.
Professor and Chairman
Department of Psychiatry
Creighton University
Omaha NE

Appendix B: The RHEN Model for Behavioral Health

The Rural Health Education Network (RHEN) began in the 1980s to develop a pipeline of health professionals to serve rural Nebraska. As a "Grow Our Own Program" the University of Nebraska Medical Center (UNMC) partnered with communities across the state to provide UNMC students opportunities to receive part of their clinical training under the supervision of volunteer health profession faculty remote from the main medical campuses.

In the early 1990s the RHEN model began to link UNMC resources with junior and senior high students to expose them to health careers and provide them with role models and resources to encourage their entrance into health professions and return to rural areas upon completion of their degrees. At the same time a program called the Rural Health Opportunities Program (RHOP) began as a partnership with Wayne State College and Chadron State College to pre-admit students to health profession training upon acceptance into their undergraduate pre-health profession areas of study. RHOP now accepts students in nine different pre-professional programs and has more than a 70% success rate of students entering health professions in rural communities upon completion of their health profession education.

In 2001, UNMC received federal support through the Health Resource Services Administration (HRSA) to develop local Area Health Education Centers (AHECs) across the State to complement the activities of RHEN. The AHECs have expanded the reach of RHEN to meet the regional needs of each Center's communities and began educating students in grades as early as K-8 about health careers and healthy lifestyles. The AHEC Centers, which are independent 501-C-3 organizations, would work with local resources to assure students and communities would mutually benefit from student training opportunities in behavioral health being made available across the state through the Behavioral Health Education System and Sites. Because AHEC Centers are governed by community boards, a goal may be to include and support consumers of behavioral health services on these boards.

In the fields of behavioral health, RHEN will collaborate with local AHEC programs and work with academic institutions that provide behavioral health tracks to design early exposure and familiarization to behavioral health careers in the K-12. RHEN will also provide education to dispel the myths and misinformation surrounding mental health and behavioral health, work with academic units to develop off campus clinical training opportunities under the direction of qualified preceptors, and work with communities to provide support resources such as housing and subsistence to accommodate students at remote clinical training sites.